STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING _____ B. WING _____	R-C 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for the post-certification revisit (PCR) survey to the investigation of complaint #IN00109013 completed on 6/29/12. This visit was in conjunction with a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00113231. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00108475 and #IN00107965 completed on 5/23/12. This visit resulted in an Immediate Jeopardy. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaint #IN00103890 completed on 3/26/12. This visit was in conjunction with a PCR to the PCR completed on 6/29/12 to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12. Complaint #IN00109013-Corrected. Unrelated Deficiency cited-Corrected. Dates of Survey: 8/6, 8/7, 8/8, 8/9, 8/10 and 8/17/12 Facility Number: 000622	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING _____ B. WING _____	R-C 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	Continued From page 1 Provider Number: 15G079 Aim Number: 100272170 Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan RN, Public Health Nurse Surveyor III (8/6/12 to 8/9/12) Dotty Walton, Medical Surveyor III (8/6/12 to 8/9/12) Mark Ficklin, Medical Surveyor III (8/6/12 to 8/9/12) Joann Scott, Medical Surveyor III (8/6/12 to 8/9/12) Steven Schwing, Medical Surveyor III (8/6/12 to 8/9/12) Keith Briner, Medical Surveyor III (8/6/12 to 8/9/12) Golden Living Center-North Willow Center was found to be in compliance with 42 CFR Part 483, Subpart I and 410 IAC 16.2 in regard to the PCR to the investigation of complaint #IN00109013. Quality Review completed 8/23/12 by Ruth Shackelford, Medical Surveyor III.	{W 000}		